INSURANCE ADMINISTRATION

Interim Report on the Use of Medical Stop-Loss Insurance in Self-Funded Employer Health Plans in Maryland
MSAR #10495

December, 2015

For more information concerning this document, please contact:

Nancy Egan
Director of Government Relations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
410-468-2488

People with disabilities may request this document in an alternative format.
Requests should be submitted in writing to:

Director of Public Affairs
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
410-468-2000
800-492-6116
800-735-2258 TTY

www.insurance.maryland.gov

INTERIM REPORT ON THE USE OF MEDICAL STOP-LOSS INSURANCE IN SELF-FUNDED EMPLOYER HEATLH PLANS IN MARYLAND

I. Introduction

During the 2015 Regular Session, the Maryland General Assembly passed House Bill 552, Chapter 494,[1] (referred to herein as "Chapter 494") concerning Health Insurance-Medical Stop-Loss Insurance-Small Employers. Chapter 494 requires the Maryland Insurance Administration ("MIA") to conduct a study of the use of medical stop-loss insurance in self-funded employer health plans in the State and report to the Senate Finance Committee and the House Health and Government Operations Committee (referred to collectively herein as the "Committees") on its findings and recommendations. Specifically Chapter 494 requires the MIA to submit an interim report on or before December 1, 2015, and a final report on or before October 1, 2016.

This document constitutes the required interim report that is due and provides the Committees a brief summary of the MIA's progress in conducting the required study. Information presented in this interim report is subject to revision after additional information is obtained and further analysis is performed.

II. Medical Stop-Loss and Self-Funding Background

An employer has two options when choosing how to provide health benefit plans to their employees. The first is a "fully insured" plan in which the employer buys a group health insurance policy from a licensed insurer who has the responsibility of providing those benefits that are defined in the plan's policy. The second is a "self-funded" plan in which the employer is responsible for providing the benefits and defining the benefits of the plan. Medical stop-loss insurance indemnifies the sponsor (employer) of a self-funded health plan against benefit payments that the plan is required to pay in excess of a certain agreed amount, known as the "attachment point." AMS, Inc. v. Bartlett, 111 F.3d 358, 361 (4th Cir. 1997). Stop-loss insurance is a "third-party" line of coverage. This means the claimant who has suffered the loss is not insured under the policy. This is fundamental distinction between stop-loss insurance and group health insurance. Stop-loss is sometimes referred to as a form of reinsurance, but a significant difference between stop-loss insurance and reinsurance is the nature of the entity purchasing the coverage. Reinsurance covers a licensed carrier for its obligation under insurance policies, while stop-loss insurance covers a self-funded employer for its obligations under a health benefit plan.

Medical stop-loss insurance is defined in Maryland law as "insurance, other than reinsurance, that is purchased by a person, other than a carrier or health care provider, to protect the person against catastrophic, excess, or unexpected losses incurred by that person's obligations to third parties under the terms of a health benefit plan.[2]

[1] A copy of Chapter 494 appears in Appendix 1.
[2] Md. Code Ann., Ins. §15-129.

A medical stop-loss insurance policy usually consists of two components; a specific stop-loss attachment point and an aggregate stop-loss attachment point. The specific attachment point is the threshold over which the policyholder is reimbursed in the event that a single individual generates medical claims over the specified amount during the contract period. Contract periods are typically twelve months.[3] An aggregate stop-loss attachment point is the threshold that reimburses the policyholder in the event that total medical expenditures exceed a pre-determined amount (the "aggregate attachment point").[4] The two components of the policy provide protection to the policyholder against the risk of a single individual with a high dollar claim or against high utilization claim expenses by all individuals covered under the underlying health plan.

Most medical stop-loss policies are issued to employers who self-fund a health plan for their employees. There are a number of different factors to influence an employer's decision to self-fund a health plan. These factors include differences in the way self-funded and fully insured employer health plans are regulated, the amount of financial risk associated with self-funding versus fully insured health plans, and the prices employers are charged for administrative services when they choose to self-fund the health plan.

When an employer decides to self-fund rather than purchase a fully insured plan from an insurance company the employer is taking on the responsibility and risk instead of the insurance company. Self-funding employers decide what benefits to offer, are responsible for paying medical claims for their employees and the employees' families, and assume all of the risk for the health plan. Employers can purchase a medical stop-loss insurance policy to help mitigate the risk of self-funding the expense of certain types of claims. These claims can include high dollar but low frequency claims of a single individual covered under the underlying health plan or low dollar claims at an unusually high frequency based on the claims of all the individuals covered under the underlying health plan. Employers who purchase medical stop-loss insurance policies remain responsible if the medical stop-loss insurer fails to preform, denies a claim, if there are gaps in coverage, or if there are conflicts or inconsistencies between the medical stop-loss policy and the employer's obligations under the self-funded health plan[5]. The employer must also make decisions about how much risk to insure with a stop-loss policy, the selection of a medical stop-loss insurer, and the determination of the benefits to be covered by the self-funded plan.

Most employers with self-funded plans hire third-party administrations ("TPAs") to administer their plans. Employers hire TPAs who can offer a number of services to the employer. The services include helping the employer design the benefit package, estimate the cost associated with the entire program, ensure the health plan complies with federal law and notice requirements, provide cost management service, and provide claim management services to help the employer with enrollment issues and medical claim processing.[6]

---

[3] Milliman *NAIC Report, Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act,* May 24, 2012.
[4] *Id.*
[5] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.
[6] *Id.*

III. Medical Stop-Loss Insurance in Maryland

The regulation of medical stop-loss policies in Maryland began as a result of complaints received by the MIA shortly after the passage of the Maryland Health Insurance Reform Act in 1993, known generally as "Small Group Reform." Before the General Assembly passed small group reform, the small group market was dysfunctional. Rates charged to different small employers varied based on the experience of the group, and as a result, many small businesses could not get insurance at all. Small Group Reform established requirements for groups from 2-50 employees including guaranteed issue, guaranteed renewability, modified community rating and a standard benefit package. Many of the benefits we now see nationally as a result of the Affordable Care Act ("ACA") were included in the Maryland Health Insurance Reform Act of 1993.

In an attempt to avoid some of the requirements of Small Group Reform, the MIA received a number of complaints that some insurers were selling stop-loss policies with very low specific attachment points. It was the view of the MIA at the time that with such low attachment points, there was no meaningful self-insurance or risk retention by the purchaser and that the stop-loss policy was being used as a substitute for health insurance.

In order to protect consumers, reduce unfair competition in the insurance market and implement the public policies expressed in Small Group Reform, the MIA sought to adopt a regulation to address the issue. The regulation was challenged and the Fourth Circuit found that it was preempted by ERISA because the regulation stated that any medical stop-loss insurance policy with a specific attachment point below $10,000 did not comply with the regulation and would be deemed to be a group health insurance policy. In the court's view, by deeming the medical stop-loss policies that attached at levels inconsistent with the regulation as direct policies of group health insurance, the State impinged on the solvency and financial planning choices which ERISA vests solely in ERISA plans.[7] The Fourth Circuit, however, was careful to state that "[t]his is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states." *AMS Inc. v. Bartlett*, 111 F.3d 358, 365 (4th Cir. 1997).

In 1999, the MIA approached the General Assembly with legislation designed to address the concerns at which the regulation had been aimed, but also in keeping with the holding of the Fourth Circuit. Clearly mindful of the elements of the regulation that had resulted in the conclusion that the regulation was preempted, §15-129 of the Insurance Article required, when initially passed, that stop-loss insurance policies issued in the State have certain minimum attachment points, but, the statute is clear that stop-loss policies are not direct policies of group

[7] The Employee Retirement Income Security Act of 1974 ("ERISA") is a comprehensive federal statute regulating private employee benefit plans, including plans maintained for the purpose of providing medical or other health benefits for employees. To assure national uniformity of federal law, ERISA broadly preempts state law and assures that federal regulation will be exclusive. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" as defined by ERISA. While ERISA broadly pre-empts state laws that relate to employee benefit plans, that pre-emption is substantially qualified by an "insurance saving clause," which broadly states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Metropolitan Life Ins. Co. v. Mass.,* 471 U.S. 724, 733 (1985).

health insurance. Md. Code Ann. Ins. §15-129 (e)[8] House Bill 1086 (Chapter 683, Acts of 1999) passed and provided that an insurer may not issue, deliver, or offer a policy or contract of stop-loss insurance, if the policy has a specific attachment point of less than $10,000 or an aggregate attachment point of less than 115% of expected claims.[9]

In 2008 the MIA sponsored House Bill 272- Medical Stop-Loss Insurance. In the MIA's written testimony before the Senate Finance Committee, the MIA provided that it had received 11 complaints from employers and employees regarding the failure of a non-admitted medical stop-loss insurer to reimburse claims. Since the carrier was non-admitted, the MIA's only recourse was to refer the employers to the U.S. Department of Labor.[10] House Bill 272 (Chapter 264, Acts of 2008) addressed this issue by replacing the definition of "stop-loss insurance" with "medical stop-loss insurance" and prohibiting the sale of medical stop-loss insurance by unauthorized carriers.[11]

House Bill 552 of 2015, as first introduced, would have increased the specific attachment point from $10,000 to $40,000 and raised the aggregate attachment point from 115% to 125% of expected claims for medical stop-loss insurance. In her oral testimony in front of the House and Government Operations Committee on March 4, 2015, the bill sponsor, Delegate Pendergrass, stated that bill was in response to the ACA changing the definition of small employer from 2-50 employees to 2-100 employees effective January 1, 2016 and its possible adverse effect on the small group market.[12] In its final version, House Bill 552 (Chapter 494, Acts of 2015), changes the specific attachment point for medical stop-loss insurance to $22,500 and the aggregate attachment point to 120% effective June 1, 2015. Chapter 494 provides that the provisions of the law do not apply to medical stop-loss insurance contracts issued before June 1, 2015 as long as the policy or contract maintains a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims. In addition, Chapter 494 establishes certain protections and prohibitions for medical stop-loss insurance issued to a small employer and provides for the MIA to conduct a study. Chapter 494 took effect June 1, 2015 and terminates on June 30, 2018.

Since the enactment of Chapter 494, federal law has changed. The federal law, entitled Public Law 114-60 Protecting Affordable Coverage for Employees Act[13] ("PACE Act") revises the definition of small employer under health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50

---

[8] While not a direct form of group health insurance, it is a form of health insurance because it "appertains" to the indemnification of human beings against bodily injury and other perils identified in the definition of health insurance. *See* Md. Code Ann. Ins. Art. § 1-101(s).

[9] *See* http://mgaleg.maryland.gov/1999rs/bills/hb/hb1086e.pdf for a copy of HB 1086.

[10] *Medical Stop-Loss Insurance, Hearing on House Bill 272 before the Senate Finance Committee* , 2008 Leg., 425th Sess. (Md. 2008) (written testimony of the Maryland Insurance Administration).

[11] *See* http://mgaleg.maryland.gov/2008rs/chapters_noln/Ch_264_hb0272T.pdf.

[12] To listen to all of the testimony go to http://mgahouse.maryland.gov/mga/play/fb0f72861c3b4dd1beb2cd358209e937/?catalog/03e481c7-8a42-4438-a7da-93ff74bdaa4c&playfrom=13896132.

[13] A copy of H.R. 1624- Protecting Affordable Coverage for Employees Act appears in Appendix 2.

employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees.

IV. Requirements of the MIA's Study

Chapter 494 requires the MIA to perform an analysis of baseline data, including sample data, where appropriate, on:

(1) (i) The types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;

(ii) For self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased; and

(iii) The number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carrier;

(2) An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance;

(3) An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act;

(4) An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland;

(5) A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups;

(6) Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees;

(7) A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market;

(8) An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers:

(ii) Choosing to self-insure instead of purchasing health insurance in the small group market; and

(iii) After self-insuring, switching to small group market;

(9) An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees;

(10) An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels;

(11) An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections; and

(12) An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.

V. Methodology

As part of the medical stop-loss study, the MIA is required to solicit information from the following stakeholders: 1) carriers offering fully-insured plans in Maryland; 2) carriers offering medical stop-loss insurance in Maryland; 3) employers utilizing fully-insured health plans; 4) employers utilizing self-funded plans in conjunction with stop-loss insurance; 5) insurance producers; 6) third party administrators; 7) consumers; 8) the Office of the Attorney General; 9) Maryland counties and municipalities; and 10) the Maryland Bankers Association. To complete this multi-faceted analysis, the MIA: 1) developed a survey; 2) developed two data call letters;[14] 3) is working with the National Association of Insurance Commissioners ("NAIC") and other state Insurance Departments to gather information relevant to how medical stop-loss insurance is regulated in other states and jurisdictions; 4) is working with the insurance producer community to develop sample data sets for quoting in the self-insured market; 5) held an informational public hearing; 6) provided a platform for comments by conducting eight town hall meetings around the state; and 7) has actively solicited information from stakeholders through meetings, conference calls, and stakeholder written comments.

As part of the outreach to consumers, employers and insurance producers, the MIA conducted eight town hall meetings over the summer of 2015 in various locations across the state from western Maryland to the Eastern Shore[15]. Insurance Commissioner Redmer invited interested parties to provide opinions, questions and concerns about the recent changes to the health insurance market including changes to medical stop-loss insurance. In addition, the MIA has been actively communicating with the Maryland Association of Bankers ("MBA") and the National Federation of Independent Businesses while also working closely with the Maryland

[14] See Task One and Task Nine for further information.

[15] The eight town hall meetings were held in Salisbury, Easton, Rockville, Hagerstown, Hunt Valley, Waldorf, Annapolis and Baltimore.

Municipal League ("MML") and Maryland Association of Counties ("MACo") in order to gather information on how changes would affect the business community, local governments and consumers. The MIA remains in communication with these key stakeholders, and others as appropriate, while engaging them on the issues at hand.

As required by the study, the MIA held a public informational hearing on the topic of medical stop-loss insurance where stakeholders were invited to attend and provide written comments about the components of the medical stop-loss study. The public informational hearing was held on Monday, September 28, 2015 with various stakeholders providing oral comments.[16] Stakeholders were encouraged to provide written comments. Among the stakeholders who provided written and oral comments were small business owners, MACo members, MML members, MBA, producers and consumer advocates.[17]

VI. Chapter 494 Analysis Progress Report

Analysis Task (1): *An analysis of baseline data, including sample data, where appropriate; (i) on the types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;*
(ii) for self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased; and
(iii) the number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carriers.

The Maryland Insurance Administration does not regulate employer self-funded health plans, which are often offered by an employer who purchases a medical stop-loss insurance policy. Medical stop-loss insurance policies function to limit significant risk to employers as a result of high dollar claims and high utilization claims that may arise. The MIA's regulatory oversight extends only to the medical stop-loss policies; it does not extend to the self-funded plan that covers the employees of the self-funded employer. In contrast, the MIA has jurisdiction over fully insured health benefit plans.

In the fully insured small group market, there are 13 carriers offering 330 small group medical plans on and off the Exchange for calendar year 2015. This includes HMO, PPO and POS product types with actuarial value metal levels of all four types, Platinum, Gold, Silver and Bronze.[18] Unlike the fully insured market, the MIA cannot require employers to submit self-funded health plan contracts and rates for review because of MIA's regulatory constraints. Therefore, the MIA does not have any information readily available on the types/costs of health

[16] For a copy of the transcript of the public hearing, see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Transcript.pdf.
[17] For a full list of the written comments, see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf.
[18] A sample of approved 2015 monthly rates for the lowest-priced bronze, silver, gold and platinum plans from Maryland's four rating areas is attached in Appendix 3.

benefit plans and number of plan designs available within the self-funded health plan market. As part of the MIA data call/survey the MIA is requesting this type of information from the medical stop-loss carriers (part of Task (1) (iii)). In addition, the MIA is currently gathering information regarding the market share by medical stop-loss carrier in 2015. The market share by carrier in the fully insured small employer market as of December 31, 2014 is as follows:

Market Share for the Fully Insured Small Group Market

Name	Number of Covered Lives	Market Share by Covered Lives
Aetna Health Inc (PA Corporation)	3,836	1.20%
Aetna Health Ins Co	20	0.01%
Aetna Life Ins Co	9,776	3.05%
CareFirst BlueChoice Inc	159,164	49.68%
CareFirst of MD Inc	23,972	7.48%
Cigna Health & Life Ins Co	181	0.06%
Coventry Health & Life Ins Co	12,304	3.84%
Coventry Health Care of DE	13,424	4.19%
Evergreen Health Cooperative Inc	11,286	3.52%
Group Hospitalization & Medical Services	46,028	14.37%
Kaiser Foundation Health Plan	7,603	2.37%
Kaiser Permanente Ins Co	19	0.01%
Mamsi Life & Health Ins Co	9,458	2.95%
Mid West National Life Ins Co of TN	0	0.00%
Optimum Choice Inc	8,106	2.53%
UnitedHealthcare Ins Co	12,024	3.75%
United Healthcare Mid-Atlantic	3,206	1.00%
Total	320,407	100.00%

In addition, federal law has changed since this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Based on this federal law, Maryland employers with 51-100 employees will continue to be classified as large employers, meaning there will not be a shift in the pricing for the small employer from large group to small group. Due to the recent change in federal law, the MIA suggests that addressing the areas of study in Task One dealing with pricing for employers with 51-100 employees in the marketplace is not relevant at this time.

In order to understand the dynamics of Maryland's medical stop-loss insurance market, the MIA developed a data call letter and survey to request information from the carriers

providing medical stop-loss insurance in Maryland.[19] The data call letter/survey was sent to the medical stop-loss insurers and requested information for policies issued during the time period of June 1, 2014 through May 31, 2015. The letter was submitted to the 69 medical stop-loss carriers identified as selling medical stop-loss insurance in the State. The survey requested information regarding minimum group size, minimum attachment points written, and pricing of the product. The survey results will help provide an overview of the individual and aggregate attachment points for medical stop-loss insurance purchased for self-insured plans (Task (1) (ii)). Based on the survey response, the MIA will be able to determine the number of medical stop loss policies written in the 2-50, 51-100 and 100+ employee markets and minimum individual and aggregate attachment points for each market. The MIA also is asking medical stop-loss carriers to provide specific information regarding the number of plan designs available if they offer management services for the self-funded portion of the plan.

Additionally, the MIA reached out to the medical stop-loss carriers, as well as the insurance producer community, to help develop the parameters for quoting in the self-insured market. Working with these groups, the MIA developed two sample employers in the 2-50 market. Each medical stop-loss carrier will be asked to quote the two sample employer groups in four different zip codes that represent the four rating regions of Maryland. The sample data includes employer zip code, SIC code,[20] employee age, number of dependents, and dependent ages. For the self-insured market, the MIA is requesting pricing based on an individual attachment point at $10,000 and aggregate at 115%[21] of expected claims as well as pricing based on an individual attachment point at $22,500 and aggregate 120% of expected claims. The baseline design of the plan is based on the CareFirst BlueChoice HMO HRA/HSA $1500 plan, the largest plan in the largest small group product by enrollment in the first quarter of 2014 in Maryland. The request for quoting in the self-insured marketplace will be sent to only those medical stop loss carriers who operate in the 2-50 market.

However, any information and pricing received from the medical stop-loss carriers will be merely anecdotal. Task One does not require any comparison of pricing. Any attempt to compare pricing in the small group self-insured market versus the fully insured marketplace would not be practical and would require actual claims experience, pricing from TPAs, and other components that make up the cost of self-insuring.

Analysis Task (2): *An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance.*

[19] A copy of the data call letter and survey appears in Appendix 4.

[20] Standard Industrial Classification ("SIC") codes are four-digit numerical codes assigned by the U.S. government to business establishments to identify the primary business of the establishment. The first two digits of the code identify the major industry group, the third digit identifies the industry group, and the fourth digit identifies the industry.

[21] Chapter 494 provides that a policy or contract of medical stop-loss insurance issued or delivered before June 1, 2015 may maintain specific attachment points of no less than $10,000 and an aggregate attachment point of no less than 115%. Policies issued or offered after June 1, 2015 are subject to the higher attachment points of $22,500/120%.

The MIA has initiated research regarding the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance in contiguous states. The MIA is consulting the NAIC's "Stop Loss Coverage Chart" from the *Compendium of State Laws on Insurance Topics* (last updated May 2015). Staff will directly consult contiguous states to acquire information as necessary for the final report.

Analysis Task (3): *An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act.*

The MIA surveyed carriers in Maryland's fully insured group market on the number of employers with 51 to 100 employees during its 2016 ACA rate review process, the survey showed there were 1,556 employer groups with 51-100 employees in 2015. Since the enactment of Chapter 494, federal law has changed. The new federal law, the PACE Act, revises the definition of small employer under the health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Since the PACE Act retained the definition of small group at 50 employees, there will not be any shift of employers from large group to small group as employers with 51-100 employees will continue to be considered large employers.

Analysis Task (4): *An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland.*

The MIA has initiated research regarding the statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states in which the requirements are different from those in Maryland. The MIA will rely heavily on the NAIC's "Stop Loss Coverage Chart" from the *Compendium of State Laws on Insurance Topics* (last updated May 2015), which provides a multi-jurisdiction analysis of state stop loss laws, in the final report.

Analysis Task (5): *A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups.*

The NAIC adopted the Stop Loss Insurance Model Act (#92) in 1995. Based on a 1994 actuarial study by Coopers and Lybrand, Section 3 of the model set the following minimum attachment points, giving the Commissioner the authority to adjust them for inflation:

A. (1) An insurer shall not issue a stop loss insurance policy that:

(a) Has an annual attachment point for claims incurred per individual which is lower than $20,000;

(b) Has an annual aggregate attachment point, for groups of fifty (50) or fewer, that is lower than the greater of:

(i) $4,000 times the number of group members;
(ii) 120 percent of expected claims; or
(iii) $20,000;

(c) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than 110 percent of expected claims; or

(d) Provides direct coverage of health care expenses of an individual.

In the fall of 2011, a 2012 charge was adopted for the ERISA (B) Working Group of the NAIC Regulatory Framework (B) Task Force to update the stop loss model act to account for medical inflation. A new study was commissioned utilizing current data in order to update the attachment points. The Milliman Group was chosen to do the study, and on May 24, 2012, they issued their report entitled: *Milliman NAIC Report: Statistical Modeling and Analysis of Stop Loss Insurance for Use in the NAIC Model Act.* Based on the Milliman Report, guideline amendments to the model act were drafted that included raising the annual attachment point for all groups to $60,000 and raising the aggregate attachment point for groups of 50 or less to the lower than the greater of (i) 15,000 times the number of group members; (ii) 130 percent of expected claims; or (iii) $60,000.[22] The motion to adopt the guideline amendments failed at the 2012 Fall National Meeting.

From 2013 to 2015, the ERISA (B) Working Group continued its study of the stop-loss issue by composing a comprehensive white paper on this subject. The NAIC White Paper entitled "*Stop Loss Insurance, Self-Funding and the ACA"* was adopted at the Executive/Plenary session of the NAIC on August 18, 2015.

The MIA will consider the NAIC Model Law on stop-loss insurance and the NAIC's recently published white paper as part of its research for this study. The following resources may also be consulted:

- "Statistical Modeling and Analysis of Stop- Loss Insurance for Use in NAIC Model Act." Milliman, Inc. Prepared for the NAIC, May 24, 2012.
- Modeling Employer Self-Insurance Decisions After the Affordable Care Act. Published in: HSR, Health Services Research, v. 48, no. 2, part. 2, Apr. 2013, p. 850-865.
- Research conducted by the Kaiser Family Foundation (www.kff.org).
- Any resources from the National Academy for State Health Policy concerning guidance, recommendations, or model legislation regarding medial stop-loss insurance.

Analysis Task (6): *Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees.*

Since the enactment of Chapter 494, federal law has changed. The new federal law, the PACE Act, revises the definition of small employer under the health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public

[22] *Guideline Revisions to Stop Loss Insurance Model Act (#92), July 2, 2012 Draft.*

Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. One reason this task was created was due to the concern that employers with 51-100 employees, who were considered large employers, would be considered small employers in 2016, and may decide to self-insure rather than participate in the small group market. Since Maryland employers with 51-100 employees will continue to be considered large employers, there does not appear to be a reason to assume that there will be a major shift in Maryland of employers in the 51-100 market into the self-insured market. In fact with the higher attachment points required by Chapter 494, as of June 1, 2015, the portion of risk that must be assumed by the employer with 51-100 employees for the payment of claims under a medical stop-loss insurance policy has risen and may act as a disincentive for those employers in 2016.

Since the PACE Act retained the definition of small group at 50 employees, the incentive and disincentives below focus only on employers with 2 to 50 employees. In 2016, small employers with significant health insurance premium increases could reduce operational expenses by exploring the possibility of self-insurance, reviewing their fully-insured plans for possible savings options such as changing deductibles or disbanding their group and advising their employees to seek coverage elsewhere including entering into the individual market.

Some of the incentives for a small employer in 2016 to purchase a health plan in the small group market is the policy defines the plan's benefits and the insurer assumes responsibility for providing those benefits.[23] Additionally the policy contains the protections of the ACA including the provisions of the essential health benefits. Employers also may have an easier time with budgeting and cash flow since their premiums are fixed and employers know what they will be paying every month.[24] Finally, employers may want to purchase coverage, as opposed to not offering any coverage, to retain employees.

A small employer considering self-funding the employees' health plan in conjunction with the purchase of medical stop-loss insurance should understand that the employer assumes all of the risk that comes with self-funding a health plan, including the risk of high dollar claims and high utilization claims, and the financial responsibility if the medical stop-loss insurer fails to perform in any way.[25] The price and contract of a medical stop-loss policy can drastically change from year to year because medical stop-loss policies are written based on claim experience. An additional disincentive for self-funded plans is that the employer must pay claims as they are incurred and the timing of those claims is beyond the control of the employer. This can result in unpredictable cash flow. Additionally, with the higher attachment points required by Chapter 494, as of June 1, 2015, the portion of risk that must be assumed by the employer with 2-50 employees for the payment of claims under a stop-loss insurance policy has

[23] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015.* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.
[24] *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA),* Technical Report, RAND Health, 2011: http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf .
[25] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015.* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

risen and acts as a disincentive for those employers in 2016. When attachment points rise, there is greater financial risk for the employer.

However, some of the incentives for a small employer who self-funds the employees' health plan are that the employer's benefit plans are exempt from state insurance regulation. Self-funded plans are subject to federal regulation under ERISA, HIPAA and the ACA.[26] Self-funded plans often have very few minimum coverage requirements and plans cannot be subject to rate regulation because they have no rates.[27] Small employers who offer self-funded health plans to their employees in conjunction with medical stop-loss insurance are able to define the benefits for their plan for their employees and are not subject to Maryland mandated benefits.

Another option that small employers may consider in 2016 and going forward is disbanding their group health plan as a cost-saving measure and advising their employees to seek coverage elsewhere including entering into the individual market. However, as shown in the Maryland rate charts below, the small group market health insurance rates overall will decrease by 1.8% in 2016 including a 3.2% rate decrease by the carrier representing 57% of the small group market. These declines in the small group market can be attributed to increased competition and two decades of reform in the State's small group market.

2016 Rates

Carriers in the individual market	Average Rate Change approved	Market Share
All Savers Insurance (A UnitedHealthCare Company)	-3.2%	0%
CareFirst BlueChoice Inc.	19.8%	72%
CareFirst of Maryland Inc.	26.0%	14%
Cigna Health and Life Insurance Co.	-3.3%	0%
Evergreen Health Cooperative	9.5%	1%
Group Hospitalization and Medical Services Inc. (A CareFirst Company)	26.0%	9%
Kaiser Foundation Health Plan of the Mid-Atlantic States	10.0%	3%
UnitedHealthCare of the Mid-Atlantic Inc.	-0.5%	1%
Total	20.5%	100%

Carriers in the small group market	Average Rate Change approved	Market Share
Aetna Health Inc.	5.3%	6%
Aetna Life Insurance Co.	7.5%	7%
CareFirst BlueChoice Inc.	-3.2%	57%
CareFirst of Maryland Inc.	-16.9%	2%
Evergreen Health Cooperative	8.9%	5%
Group Hospitalization and Medical Services Inc. (A CareFirst Company)	-16.9%	7%
Kaiser Foundation of Health Plan of the Mid-Atlantic States Inc.	5.5%	3%
MAMSI Life and Health Insurance Co. (A UnitedHealthCare Company)	1.7%	4%
Optimum Choice (A UnitedHealthCare Company)	-2.9%	3%
UnitedHealthCare Insurance Co.	1.7%	4%
UnitedHealthCare of the Mid-Atlantic	1.7%	1%
Total	-1.8%	100%

At the same time individual market rates will increase 20.5% overall in 2016 including a 19.8% increase by the carrier representing 72% of the individual market. In the individual

[26] Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA), Technical Report, RAND Health, 2011: http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf.

[27] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

market health insurers have sought rate adjustments in response to significant changes in regulation and market dynamics over the past two years. Individual rates are moving more closely in-line with small group rates. This makes sense because the individual market is now being offered under the same set of rules that have applied to the small group market over the past 20 years in Maryland including guaranteed issue; community rating; and comprehensive benefits. While the option of disbanding their group as a cost-saving measure may seem attractive to the small employer, rate convergence will continue between individual and small group rates and likely result in individual rates that are very close to those of the small group market, if not higher. In addition, some small employers may be hesitant to stop offering health coverage to their employees for fear of losing employees to other employers who do offer health coverage.

Analysis Task (7): *A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market.*

To compare the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market the MIA would need to acquire health plan documents, claim data and additional information from the TPAs. Gathering this information would be difficult and impractical. In addition, at the time of the passage of Chapter 494, there was an urgency to collect this information for employers in the 51-100 market who, effective January 1, 2016, were to be redefined as small employers. Those employers with 51-100 employees would then have been subject to possible higher rates moving from experience rating to modified community rating and may have considered self-insuring as a possible option. With the passage of the PACE Act, there no longer seems to be a need to collect this information.

Analysis Task (8): *An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers*

(i) choosing to self-insure instead of purchasing health insurance in the small group market;

(ii) after self-insuring, switching to the small group market.

Small employers are very aware of the cost of health insurance for their employees and tend to search for less expensive options. Some shop their plans in the insured market each year. Other employers may choose to self-fund health plans for their employees, if they believe that their group is healthier than the average group. The employers that choose to self-fund instead of purchasing health insurance in the small group market can create adverse selection by leaving the older, sicker, and higher risk groups for the small group market. Additionally, another factor that may contribute to adverse selection is the possibility that small employers, after self-insuring and experiencing high claims, switch back to the small group market. This concern is based on the differing underwriting standards between the two markets. Since small group market laws require modified community rating for the insured market and the self-funded market is based on an individual employer's risk profile, it is assumed that self-funded plans will be attractive to low-risk groups; conversely, high-risk groups are expected to see better rates in the modified community-rated environment of a fully-insured plan.

Maryland enacted small group reform in 1994 including guaranteed issue, guaranteed renewability, modified community rating and a standard benefit package. Many of the benefits we now see nationally as a result of the Affordable Care Act ("ACA") were included in the Maryland Health Insurance Reform Act of 1993. Since that time, small employers in Maryland have been able to either purchase health insurance in the small group market or chose to self-insure or switch back into the fully insured market after experiencing high claims. Effective January 1, 2016, under the ACA, the definition of "small group" would have expanded from an employer with 2-50 employees to an employer with 2-100 employees subjecting those employers with 51-100 employees to the small group rating rules. Employers with 51-100 employees would no longer be rated based on the experience of the employer's group, but on the modified community rating.

The NAIC White Paper, "*Stop Loss Insurance, Self-Funding, and the ACA,"*[28] provides a comprehensive assessment of the impact of stop-loss insurance on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers attempting to self-insure and then subsequently switching to the small group market.

When Chapter 494 passed there was concern that the employers with 51-100 employees with good claims experience would choose to self-insure or switch from self-insuring due to high claim experience to the small group market. Federal law has changed since this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Since Maryland employers with 51-100 employees will continue to be considered large employers, it does not appear there will be any impactful movement by small employers which would result in adverse selection that would affect the stability and viability of the small group market.

Analysis Task (9): *An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees.*

Analysis Task 9 of the report is focused on whether there is an impact on the Maryland Health Benefit Exchange ('MHBE") when small employers drop coverage for their employees. Neither the MIA nor the MHBE collects this type of data. The MHBE does not ask applicants whether they had prior coverage, whether their last coverage was group coverage, or whether they lost coverage due to an employer dropping coverage.

As a result, the MIA developed a data call letter [29] to be sent to the carriers participating in the Maryland small group market in 2015. A second data call letter will be sent in 2016 to the carriers participating in the Maryland small group market. In the letter, the MIA asked whether any of the carriers collected data regarding the reasons why small employers dropped their health benefit plans with the carriers. Only three carriers of the 13 carriers participating in the Maryland small group market in 2015 collected this data. The three carriers that collected this data represent 9.7% of the Maryland small employer market.

---

[28] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015*, Appendix A. http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

[29] A copy of the data call letter to carriers appears in Appendix 5.

One carrier reported that 605 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 605 terminating employers, 496 moved their coverage to a different carrier, while 109 dropped coverage for their employees.

A second carrier reported that 37 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 37 terminating employers, 10 moved their coverage to a different carrier, 12 dropped coverage for their employees, and 15 were unknown.

The third carrier reported that 54 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 54 terminating employers, 20 moved their coverage to a different carrier, two dropped coverage for their employees, and 32 dropped their coverage for a number of reasons including the employer was no longer in business (2), nonpayment of premium (14), change to a different market segment (12), and no remaining members (4).

None of the carriers tracked if the employees losing coverage ended up applying for coverage with the MHBE. Employees losing coverage have the option of purchasing directly from a carrier in the individual market, enrolling under a spouse's group coverage, purchasing through the MHBE, or not purchasing coverage. For employees who have higher incomes (over 400% of the federal poverty line), there would be no advantage to purchasing new coverage through the MHBE, as the reason for purchasing through the MHBE is to avail oneself of premium tax credits, and these higher income employees would not qualify for the premium tax credits.

The data provided indicated that employers were not dropping coverage for their employees, but instead changing carriers when they terminated their prior coverage. The 3 carriers that provided data in response to the survey did not represent the majority of the Maryland small group market. Therefore, we cannot assume that the data described above would apply to the entire small group market.

One reason this study was created was due to the concern that employers with 51-100 employees, who were considered large employers, would be considered small employers in 2016, and may decide to drop coverage rather than participate in the small group market. Federal law has changed since the bill requiring this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a State requires the small employer definition to be expanded to 100 employees. Since Maryland employers with 51-100 employees will continue to be considered large employers, there does not appear to be a reason to assume that there will be a major shift in Maryland employers dropping coverage in the future. Therefore, there does not appear to be any evidence that there will be a major impact on the MHBE due to small employers dropping coverage for their employees.

Analysis Task (10): *An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels.*

Medical stop-loss insurance policies have two different attachment points: a specific attachment point and an aggregate attachment point. Stop-loss premiums vary by the levels of attachment points, among other things. For example, if the attachment point is higher, the stop-loss premium would be lower.[30]

Medical inflation is a potential factor that could impact stop-loss rates. A high medical inflation rate could cause costs for specific stop-loss coverage to increase at rates higher than the general inflation rate. Also, a company may have paid claims that came close to the attachment point, but did not reach it. With medical inflation, this would cause the claim to go over the attachment point. Therefore, a stop-loss carrier would have to cover a claim it would not have covered in the previous year. This type of event is known as "deductible erosion" in the industry. Maintaining the current statutory levels would mean business as usual in the industry. Small group employers who self-insure their health benefit plans could continue to enjoy the low attachment points for both specific and aggregate stop-loss, which would continue making self-insured health benefit plans affordable, but raising the cost of the medical stop-loss insurance, as more claims would be paid under a medical stop-loss policy with lower attachment points. Adjusting the current statutory levels to a higher point could steer some small group employers away from the self-insured health insurance market. These employer groups may move into the fully insured market or may decide to drop their coverage if the fully insured premium is not affordable.

The MIA is currently reviewing the Milliman *NAIC Report: Statistical Modeling and Analysis of Stop Loss Insurance for Use in the NAIC Model Act* prepared for the NAIC, May 24, 2012 and any regulatory or legislative activity in other states addressing medical inflation and medical stop-loss attachment points and will summarize the findings in the final report.

Analysis Task (11): *An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections.*

The NAIC in its *Stop Loss Insurance, Self-Funded and the ACA, White Paper, NAIC, 2015* specifically addressed regulatory options to protect policyholders, consumers, and health care providers. Some of the options suggested by the NAIC included 1) minimum policy standards; 2) risk transfer; 3) disclosure; and 4) rate review.

Minimum policy standards are suggested as an option to protect employers and to ensure a level playing field for all insurers. One of the key minimum standards suggested is to address the issue of "lasering". "Lasering" is defined by the NAIC as "assigning different attachment points or deductibles, or denying coverage altogether, for an employee or dependent based on the health status of the individual."[31] Other minimum policy standards suggested to be included for employers were provisions regarding mid-term rate increases and payment of claims.

Chapter 494 has included certain statutory consumer protections for small employers who utilize medical stop-loss insurance. Chapter 494 adds protection against "lasering" within the

[30] Appendix 6 is a sample stop-loss base premium rate by specific attachment points from a carrier with the largest stop-loss market share. Appendix 7 is a sample of aggregate stop-loss rates by attachment points and group size.
[31] *Stop-Loss Insurance, Self-Funded and the ACA, White Paper, NAIC, 2015*.

contract and provides additional protections for the employer regarding rates and payment of claims. Specifically, §15-129(e) of Chapter 494 addresses "lasering" by prohibiting: 1) imposing higher cost sharing for a specific individual within a small employer's health benefit plan than required for other individuals within the small employer's health benefit plan; 2) decreasing or removing stop-loss coverage for a specific individual within a small employer's health benefit plan; or 3) excluding any employee or dependent from a policy or contract on the basis of an actual or expected health status–related factor or condition, including physical or behavioral health, including mental illness or substance use disorder; claims experience; medical history; receipt of health care; genetic information; disability; and any evidence of insurability, including conditions arising out of acts of domestic violence against an employee or dependent. Additionally, §15-129 (f) of Chapter 494 provides protection for the employer regarding rates and payment of claims by requiring guaranteed rates for at least 12 months, without adjustment, and paying stop-loss claims incurred during the policy or contract period and submitted within 12 months after the expiration date of the policy or contract.

For risk transfer, the NAIC Stop loss Model Act (#92) adopted in 1995, sets minimum standards for attachment points, which the NAIC suggests states review to determine whether they are appropriate to market conditions in their state. Those attachment point standards for small group are $20,000 for a specific attachment point and for an annual aggregate attachment point that is lower than the greater of: (i) $4,000 times the number of group members; (ii) 120 percent of expected claims; or (iii) $20,000. Maryland passed legislation in 1999 with attachment points lower than the NAIC model. Until the passage of Chapter 494, an insurer could not issue, deliver, or offer a policy or contract of stop-loss insurance, if the policy has a specific attachment point of less than $10,000 or an aggregate attachment point of less than 115% of expected claims. This applied to all policies of medical stop-loss insurance regardless of the size of the employer. Chapter 494 raises the specific attachment point for medical stop-loss insurance to $22,500 and the aggregate attachment point to 120%, effective June 1, 2015.

The NAIC also suggested that state regulators consider some type of disclosure to the small employer. A small employer is unlikely to have dedicated staff who are trained in understanding the differences between a fully insured plan and that of a self-insured plan. Stop-loss insurance products are exempt from certain requirements under state or federal health insurance law, including the ACA, and include certain financial risks. Small employers may benefit from education on the risk they are assuming in self-funding a health plan, as well as protections that they should be looking for when they shop for a medical stop-loss insurance policy. NAIC suggestions include that any disclosure developed include uniform key terms and definitions, ensure stop-loss policy purchasers receive and understand all necessary information and specific contract terms be disclosed as well. Chapter 494 has included a disclosure requirement be given to the small employer, in a form and manner approved by the Commissioner and before entering into a policy or contract for medical stop–loss insurance. The disclosure is required to include the total costs of the policy or contract; the dates on which the policy or contract takes effect and terminates; the provisions for renewing the policy or contract; the aggregate attachment point and the specific attachment point for the policy or contract; and any limitations on coverage. The MIA adopted such a disclosure by regulation. *See* COMAR 31.10.43, which becomes effective January 1, 2016.

An additional NAIC suggestion for those states that perform rate review of medical stop-loss premium rates, is to consider whether the premiums are reasonable in relation to the benefits conferred, whether the premium is allowed to vary based on the claims submitted by the employer, and for those employers without credible experience, to examine how the insurer calculates "expected" claims when determining compliance with minimum aggregate attachment point requirements. In Maryland, insurers are required to obtain the approval of the Maryland Insurance Administration prior to use of a medical stop-loss premium rate. During the rate review process, the MIA reviews whether the premium is reasonable in relation to the benefits being offered. The MIA reviews the actuarial assumptions and methods used by the insurer to ensure adequacy of these assumptions. Furthermore, for all medical stop-loss premium rate filings, the MIA requires that the filing be signed by an actuary meeting the minimum qualification standards of the Society of Actuaries, attesting that the information contained in the premium rate filing is accurate and complies with Actuarial Standards of Practice Number 8.

At the time of filing this interim report, the MIA has received only one written comment on consumer protection, which the MIA is reviewing.[32] Additionally, the MIA is continuing to review recommendations for consumer protection suggested by the NAIC and interested parties while also monitoring and assessing how other states address regulatory options to provide consumer protections.

Analysis Task (12): *An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.*

The MIA is currently working with the small employer community as well as the Maryland Association of Counties ("MACo") and the Maryland Municipal League ("MML") to provide feedback on the impact of the changes to the attachment points as well as the new consumer protections that were implemented by Chapter 494.

The MIA held a Public Informational Hearing on Medical Stop-Loss Insurance on September 28, 2015 to gather public opinion on the recent changes to the State stop-loss laws. MACo and MML provided written testimony voicing the organizations' concern for the Maryland Local Government Health Cooperative ("Cooperative").[33] The Cooperative is an insurance pool whose membership is limited to Maryland's counties, incorporated cities, and towns, and was established to allow public entities to more efficiently finance their employee health benefits through self-funding. The Cooperative was formed in 2010 and currently has 19 local government members. For small counties and municipalities of all sizes, the Cooperative

[32] The Maryland Women's Coalition for Health Care Reform requested several areas to be addressed including prohibition of early termination or rescission other than for fraud or intentional misrepresentation, requiring a carrier to honor any claim which the employer is legally obligated to pay, stronger disclosure requirements, and transparency relating to the collection and use of individualized demographic and health data with an opt-in requirement for individuals. For a copy of the Maryland Women's Coalition for Health Care Reform's written comments see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf.

[33] A full copy of MACo's and MML's written comments in response to the MIA's Public Informational Hearing on Medical Stop-Loss Insurance held on September 28, 2015 can be found at: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf .

provides an opportunity to maintain relatively high benefit offerings for their employees through self-insurance, an option that would be unavailable to them acting alone. Through the Cooperative, counties and municipalities come together and support each other by sharing in both the risks and benefits of self-insurance. According to MACo and MML, these local governments avoid unexpected and cost-prohibitive premium increases from year-to-year. In turn, any savings are passed on to both taxpayers and employees.

Both MACo and MML are working to provide the MIA with additional information regarding the current self-insured market and the impact of changes to the State medical stop-loss law on local governments. Specifically, MACo is currently collecting information relative to medical stop-loss carriers and the specific and aggregate attachment points for the counties that self-insure. MML is conducting a survey of its membership based on the study language in Chapter 494 and will compile that information. Benecon Group, Inc., the actuary for the Cooperative who specializes in developing and managing municipal health insurance cooperatives, including counties, school districts, townships, boroughs and other local government units is compiling information regarding the specific financial impact of the changes to the attachments point on the local governments.

Additionally, the medical stop-loss public hearing and the town hall meetings that were conducted by the MIA during the summer provided a forum for small employers to provide feedback about the impact of the changes made by Chapter 494. As of the date of the interim report, the MIA has not received any comments from either the local governments or small employers reacting negatively to the consumer protections included in Chapter 494. The MIA will continue to work with both local governments and small employers to gather information for the final report.

VII. Conclusion

Since tasked with the study, the MIA has made significant progress in the research needed to respond to the Maryland General Assembly's request for the use of medical stop-loss insurance in self-funded employer health plans in Maryland. As summarized in this interim report, a majority of tasks have been addressed and substantial information has been developed. The MIA's work plan is tailored to the list of mandated tasks and a considerable continuing effort is necessary to satisfy the requirements of Chapter 494. Consequently, at this time, it is too early to draw meaningful conclusions based on the research completed or make any specific recommendations to the Committees. However, at the time of the passage of Chapter 494, there was an urgency to collect certain information for employers in the 51-100 market who, effective January 1, 2016, were to be redefined as small employers. Those employers with 51-100 employees would then have been subject to possible higher rates moving from experience rating to modified community rating and may have considered self-insuring as a possible option. Certain tasks, Task One (certain parts), Task Three, Task Six, Task Seven, Task Eight and Task Nine were designed to address the issue of the change of small group definition effective January 1, 2016 and its effect on the viability of the small group market. With the passage of the PACE Act keeping the definition of small employer at 50 employees for the foreseeable future, the need to collect that information no longer seems urgent or necessary. The MIA requests that certain requirements of this study be analyzed in light of the change in the federal law and the MIA be

given direction on the remainder of study requirements. The MIA will be submitting its final report of findings and recommendations to the Committees on October 1, 2016.